MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC)
COMMISSION MEETING MINUTES
Wednesday, September 28, 2005
1600 – 9th Street
Sacramento, CA 95814

I. Call to Order.

Chair Darrell Steinberg called the meeting to order at 10:15 a.m.

Chair welcomed the public and thanked the Commissioners for traveling. He promised some geographical diversity in terms of where the Commission holds the hearings. He announced that next month we are holding our hearing on the issue of housing and the potential housing bond in Los Angeles on October 26, 2005. The meeting will be hosted by Commissioner Ridley-Thomas.

II. Approval of Minutes from the first two OAC meetings:

MOTION: Chair Steinberg requested a motion to approve the minutes of the July 7, 2005 and July 22, 2005 Commission meetings.
Minutes were approved unanimously.

III. Business Items:

The next Commission meeting will be on October 26, 2005 in Los Angeles. It is going to be specific to the issue of housing. Mr. Ridley-Thomas has graciously agreed to organize and host a tour for us of skid row and to also show us some of the model housing options that have worked for some people in LA County and what we can do with an aggressive housing strategy for more people.

Chair Steinberg thanked Commissioner Ridley-Thomas for being our liaison in LA County.

Dates for future meetings:
Since the Tuesdays and Wednesdays meeting schedules were not working for some of the Commission members, Chair Steinberg suggested that maybe we can hold the Commission meetings on Fridays.

Introduction: Chair Steinberg introduced Mr. Richard Van Horn, Principal Consultant to the Commission.

Chair Steinberg said a special thank you to the Attorney General's office for bringing Ms. Rose King on board.

IV. Public Comment.

Comments were made by a total of six people. Topics ranged from Native American concerns, Native American inclusion, consumers and survivors as experts on a wide array of mental health topics to present at Mental Health Services Oversight and Accountability Commission (MHSOAC) meetings, to schedule formal presentations by advocacy agencies.

It was brought to the Commission's attention that anyone under the age of 18 was not allowed to participate or attend the events where the family members are asked to participate.

Chair Steinberg stated that we will ask the Department and some of the county agencies to report back to the Commission on how we make sure that children are invited and included in an event.

V. Roll Call:

Present were Commissioners Carmen Diaz, F. Jerome Doyle, Saul Feldman, Linford Gayle, Karen Henry, Darlene Prettyman, Mary Hayashi, Patrick Henning, Kelvin Lee, Andrew Poat, Mark Ridley-Thomas and Darrell Steinberg.

Absent: Commissioners William Lockyer, Wesley Chesbro, Gary Jaeger and William Kolender.

Tricia Wynne represented Commissioner Lockyer.

Staff present: Richard Van Horn, Principal Consultant; Poppy Johal, Secretary.

VI. Presentation by California Rural Indian Health Board:

Chair Steinberg gave a little backdrop before the start of the presentation.

It was brought to our attention some weeks ago that there has been some tension within the Native American community about their feeling of lack of inclusion within the various stakeholder processes. The Native American communities are a very important part of California and very important part of this Act given some of the history of treatment and what we know to be some real issues within the communities relating to mental health and substance abuse. We want to make sure as a Commission, I know that the Department wants to make sure that your concerns are fully integrated into the implementation of this Act. The meeting with Dr. Mayberg and the Department's staff three or four weeks ago was a start. This is another step, so, we welcome you.

Mr. Mark LeBeau
Health Policy Analyst
California Rural Indian Health Board, Inc.
Regarding the issue of Native American participation in the mental health services funding, there is lack of mental health funding to meet certain needs of our people in our communities. We have run into what we feel are "roadblocks" with counties in trying to participate in the stakeholder processes.

We feel that we are not getting the amount of inclusion that we really need.

Ms. Wynne: Have you been attending the stakeholder meetings in these counties and try being able to work?

Mr. LeBeau: Yes, we have been attending where we have been invited. In some cases, Indian organizations have not been notified of the meetings and so the meetings have gone on without the community input. It is important to know that there are at least 36 Indian health programs that provide mental health services. There is a history of counties not willing to share their resources and subcontract with Indian organizations. We have done a tremendous amount of work and after all the data has been compiled and formally put together, and done all the work, but at the end of the day it's just a big defeat for our people.

Commissioner Henry: You said that you have gone to the stakeholder meetings that you were invited to. All the stakeholders and interested parties were notified by the web. Were you not aware of that resource?

Mr. LeBeau: In Sacramento county, the Director of the Sacramento Native American Health Center called up and had a talk with one of her other colleagues in another health organization who just happened to have received a letter of invitation to the local stakeholder meeting. We are the only Native American organization in the greater Sacramento area that provides services and we were not notified. She made a call to the stakeholder representative and was told that there are no Native Americans in Sacramento. We are afraid that we are not getting any funding at all.

Mr. LeBeau asked the Commission's help in this issue to submit a proposal.

Chair: I am really interested in understanding whether or not these are sins of omission or co-mission. For example, the comment that attributed to somebody from my county that there are no Indians here, have there been comments along those lines that tribes are sovereign and therefore, essentially yourself. Are you sensing any of that or is it more an ignorance of the kind that you just described where people don't understand that there are real issues in need within your communities?

Mr. LeBeau: At one of the very first Cultural Competency stakeholder meetings I attended, I was informed that Indian tribes weren't included in the initiative and therefore, no money would flow into these communities. And our response was, well,

that's fine and possibly at tribal level that can be asserted but there are Indian organizations within the community that are non-profit that serves the needs of Indians in regards to health care that definitely should be able to access the funding. So, there has been confusion there.

Chair: One thing I know I am going to want to hear before this conversation is done here today, is some response from the county and also sub-counties, also, some response from the Department itself just in terms of understanding these concerns, what on your ends you are planning to do about them so we can figure out our role.

Commissioner Poat: Although I would not be guided exclusively by legal precedent, it would be helpful to know, I don't know if the Native American community has different legal standing than any other community in the county, or is this just historic lack of working together? I don't know what that barrier is?

Mr. LeBeau: Indians have their own designation similar to State but that's why I raised the issue of Indian non-profit organizations that do work with the Indian tribes and the community.

Ms.Connie Reitman
Executive Director
Inter-Tribal Council of California, Inc.

Just for clarification, tribal sovereignty is a relationship that exits between the Federal government and the tribes. Essentially, in programs, tribal people should be considered just like any other citizen in the State in which you reside. I think that because of lack of understanding of that special relationship from the Federal government to the tribe that has somewhat clouded the picture. For those the purposes of MHSA, tribal people should be treated just like any other citizen in the State of California. And it is unfortunate that this dialogue continues in questioning whether they are eligible for services or should be provided services.

Commissioner Poat: Is that a settled legal opinion?

Ms. Reitman: Yes. We are citizens of California and should be entitled to the same benefits. I think history has created that continuing ongoing question as to whether tribal people are entitled to the same benefits that other people are. But we wanted to take this opportunity to educate as many people as we can because this law is affording us an opportunity to really transform what has been happening with tribal people. We are continuing to work with the Dept. of Social Services, we are currently working with the Attorney General's office to create some policies to clarify the rules effecting tribal communities. We just need a chance to get our foot in the door.

Chair: This is what we are going to really begin exploring today and we are going to develop a strategy with the counties, with our State department, Commission and with our stakeholders here to address the issue.

This Act was written in the first place, to not be formula driven. The county applications are deemed to be competitive, in other words, they have to meet the criteria of the Act and obviously, including cultural competency. As an Oversight Commission, our job is to make sure that the county plans reflect the diversity of the communities throughout California. Not based on formula.

Ms. Carol Hood: The Department of Mental Health met with representatives of the Native American communities on August 23, 2005. What we feel the first step in forging a partnership, is to look at what the needs are and the best strategy to serving this population and that step, what we strongly promote, is an integrated system at the county level. So, Dr. Mayberg's first priority is to try to forge a functioning relationship with the counties. There is a dinner that's going to be between the counties, the State Department of Mental Health, representatives of the Native American communities on the 12th of October. There will also be a subsequent meeting with the Department of Mental Health and it feels like we are on a path of working together to find solutions.

Ms. Pat Ryan: We have been hearing a lot from the Native American groups as well and we do want to learn and do a better job. I met personally with some of the representatives about a month ago. As a result of that meeting, I took back some very troubling concerns about response at the individual county level. I went back and talked to all of our directors. I think it's very clear to everybody that we need to do a better job of learning about Native American cultures and doing a better job of serving them. There are lot of expectations from a lot of people to do a lot of things that haven't been done very well or haven't been done at all for many, many years. It's also clear that Native American communities are priority.

I have spoken to the Chairs of our Ethnic Services committee and to California Institute of Mental Health (CIMH) about making sure that we talk to the representatives of the Native American community and incorporate them in our cultural competency process and that we incorporate them in the trainings that happen for county staff on a regular basis.

Commissioner Feldman: I suspect that almost any minority group in California does not feel well served by the mental health system. Not just Native Americans but other minority groups as well.

I am not sure there is any reason to feel optimistic when the neglect has been gone on for so many years. But somehow it's going to change. California is only one of a handful of States throughout the country that has intergovernmental relation situation in which the counties are so dominant in terms of mental health services. One has to question, to what extent is California's system substantial responsibility for county government, to do the kind of things that we want them to do. To what extent does the structure suggest that steps be taken. I must say that given what I have heard today and given what I have experienced in the past, it maybe time that at some point, that we need to consider at what extent it becomes structure.

Commissioner Prettyman: I want to know if there is anything that is doing good for the American Indians. Is there anything that we could use as evidence based practice that is going on?

Mr. LeBeau: Department of Social Services has a program where they provide funding for 36 Indian Health organizations. It provides a council that provides culturally competent services to Indian communities in California. That is an example of great work in California.

Chair: We need to understand the models so that we can push for their replication with obvious sense of their uniqueness to particular communities.

Commissioner Ridley-Thomas: It seems to me that the least we can do is perhaps instruct or define the way in which outreach could be expected in communities that have been heard from today are approached. It is a fundamental concern that is communicated, the information has gotten to them and whatever the case maybe, it seems to me that the Commission would wish to insure by the standards processes that are appropriate, there be some indication what the outreach to the respective communities has been. So, I would want to submit for consideration that we have an opportunity to review what the outreach of these respective counties so that we have a chance to verify for ourselves.

Chair: On the issue of set-aside, I think in general, set-asides are a bad idea. Because if we start going down that path, this Act will be carved up in two dozen different ways in a way that we won't be able to see the whole. Having said that, it is a potential hammer here and it is something that we ought to keep in our back pocket, so to speak, as a possibility. Not only as it applies to Native American communities but as a whole issue of cultural competency. And when it comes to this whole issue of serving underserved communities in California, we have all collectively a whole lot of work to do and so, on your particular concern in your particular communities, we will reagendize this to hear back in terms of how this is progressing and we will stay on this. But it opens up a much broader question here in terms of what cultural competency means and are we moving in a direction to turn around decades of systemic failure and at all levels of government to respond to the needs of the people who have been underserved.

Commissioner Feldman: Is there anything in the Act that would preclude the Commission from time to time, as appropriate, to make a direct grant.

Chair: The answer is no, there is nothing in the Act that prohibits that. Of course, the department has the decision-making responsibility of service side, we have the final say in approving prevention and innovation grants. We haven't yet begun to define prevention and innovation for purposes of the Act.

Commissioner Lee: I agree with your ideas of set-aside but I would hope that when we get the county plans, that we enforce the plans to do the work rather than setting a

separate set of opportunities exclusive of the plans. Because if we don't push back to the plan at the county level, we haven't addressed the root issue.

VII. Draft Year One Plan

Review of year one plan by Chair Steinberg.

We are going to establish five (5) Commission committees for year one. We are going to appoint chairs and we are going to establish committee membership. We are going to staff the committees, as well as, staff the Commission. The charge of the committee, we laid out various charges for the one year committee in which on Prevention and Early Intervention and Innovation, there are essentially going to be standing committees. For Community Services and Supports, Capital Facilities, Education and Training, there are going to be standing committee creations but they are going to be liaison committees to the already existing work of the Department of Mental Health. We are going to have a committee on Measurement of Outcomes. We are going to work collaboratively with the Department on measurement of outcomes. When it comes to Public hearings, we are going to hold at least one public hearing per quarter on what I call "big picture." We have decided that the public hearing on the issues of housing will be on October 26, 2005. Others will be on Prevention and Early Intervention, Innovation, and employment for consumers and families. We will report back to you at some point, sooner than later on by-laws including the discussion of voting rights for commission members and/or their designees.

All the committees are going to be standing committees of the Commission. The three that, in which the primary, at least the final decision making responsibility rests with the department, will also have the additional tag of Liaison Committee because they are liaison to the department.

Every Commissioner will have a lead role in the key element of the Act. Every Commissioner will have the right and ability to sit on any committee that they want.

Committee	**Co-Chairs**
Prevention	Mary Hayashi and Darlene Prettyman
Innovation	Karen Henry and Wesley Chesboro
Community Services and Support	Jerry Doyle and Tricia Wynne
Capital Facilities	Andrew Poat and Carmen Diaz
Education and Training	Saul Feldman and Patrick Henning
Measurement and Outcomes	Gary Jaeger and Kelvin Lee
Special Liaison to LA County:	Mark Ridley-Thomas
Special Liaison to Law Enforcement	Bill Kolender

Commission Chair Steinberg and Vice-chair Gayle are ex officio members of all committees.

This is what I suggest we go from here. Some time over the next week or two weeks, I am going to ask the co-chairs to set-up conference calls with Richard Van Horn and I will try to be on as many as I can, to discuss your charge and to develop a plan for each committee. That includes staffing issues and the budget. By the time of the October meeting, other members of the Commission will be asked to identify which additional committees they wish to serve. By the time of the November meeting, schedule for the committees will be set and other commission members assigned. This is to the members of the public sitting out there because what we envision is committees composed of 10 to 15 persons, of which, at least two must be consumers and two must be family members. And that each committee will develop its own work plan and meeting schedules, systems and staff. With Richard's and Linford's and my assistance, we will get you the resources that you need and help you put together a full commission. So, come the first of the year, you are running on a schedule and consistent with the one year work plan.

In response to Commissioner Diaz's concern Chair Steinberg assured that there will be at least one parent or caregiver of children on these committees.

The more difficult question will be how we involve the members of the public to make sure that the committees are of a size that are workable.

We have already put a survey question out to you, the Commission members asking you what your interests are, what we will do is take that and make a recommendation as to where Commissioners serve. If you want to do something, as a member of this Commission, you will be empowered to do so. Because we want you to spend your time where you feel you can make the greatest impact.

MOTION: Motion was made to adopt the year one work plan and also the appointment of chairs.
Motion was passed unanimously.

In response to Commissioner Feldman, Chair stated:
At this point, we know that 10% of the money is going to be set aside for workforce development; 10% set aside for fiscal infrastructure; we have 20% set aside for Prevention and then there is Community Services and Supports and the committee structure reflects those divisions. How this comes together as a whole is obviously our job and it will happen over time.

VIII. Understanding Measurement of MHSA Outcomes and Survey of Related Best Practices.

Chair: We are going to focus on the whole issue of understanding the measurement of MHSA outcomes and survey of related best practices. This is the heart of our mission to make sure we have the measurement in place to move towards the outcomes that we know are so important in alleviating the fight of untreated mental illness.

Opening remarks by Mr. Richard Van Horn:

Let me open up the discussion on outcomes with some general observations as to why we are going to be so intent on this because if we are going to be an accountability commission, we have to have a way of holding folks accountable and what are we holding folks accountable to. In the past, in the mental health community we have generally held the process accountable. You were able to go to medi-cal, you were able to collect your county general fund dollars and everybody sort of stayed off your back. That is exactly a large piece of what got us into the kind of trouble we have been in and you never knew what to expect if you were consumer/client in the system. You knew that they might give it to you but, what good was it going to do and was it going to change your life? It was very apparent in the early 80's that the system was truly broken. Around 1985/86, this is where Rose King's existence comes into serious play, was the Lt. General's task force for seriously mentally ill. Parents and businessmen and researchers went around the country saying what really works! Is there a best practice out there some where? And they found several best practices. They found the Fountain House in New York. They looked at the Act Program and found that if you had some sort of community treatment, you could in fact, keep people from returning to the hospital all the time, if you really watch what's happening. They went to Chicago and found that if you paid a lot of attention to employment, if you help people get work again, you were really changing their lives. Even as important as housing, for most of us, it's a job. If we don't have a job, we lose our place in American society. As a result of that study we came to AB 3777, the Adult System of Care pilot project which became law in 1988. As a first effort in that, it was determined that we should look at quality of life outcomes and these are really written into the law at that time. What was happening to somebody in relation to their housing? What was happening in relation to employment? What was happening in relation to social support? Were they in fact, staying out of jail? Were they in fact, using fewer hospital bed days and thereby indicating that things were on the mend. The initial results were highly encouraging. Once we settled on this business of quality of life outcomes, we started measuring them over time. What was happening with people's lives over time? The fact that life was improving over time, led us to AB 34 which eventually led us to the initiative which led us to where we are. We are in the process now of saying with the measurement and outcomes committee, as we enter this new generation, trying not just the Adult System of Care, not just Children's System of Care but, a total system of care.

Dr. Dave Pilon
National Mental Health Association of Greater Los Angeles

Today I am going to be talking to you about the outcomes, approach or some of the challenges that I think we are going to be facing in implementation of the Mental Health Services Act as it relates to the outcomes that we choose by which we would hold ourselves accountable.

The goals of my presentation today are to:

- Describe various approaches to outcome and performance measurement in mental health
- Provide specific examples of outcome measurement instruments
- Update the Commission on the direction and progress of the Performance Measurement Advisory Commission.
- Discuss difficulties in the measurement of "Recovery" as required by the Mental Health Services Act.

Generally speaking, we don't really look at outcomes in mental health. At least, not usually. This could be put more academically in terms of this fundamental information management question.

"Who receives what from whom at what cost and with what effect?"

In mental health programs are traditionally really good at the who receives what from whom at what cost but, we are pretty bad at saying with what effect.

These are the major types of outcome measures that are described by this particular author McGlynn:

1. *Clinical status* refers to how a disorder is defined, particularly in terms of the presence and severity of symptoms.
2. *Functional status* refers to the ability of an individual to perform age appropriate activities.
3. *Quality of life* measures, according to McGlynn, have the "objective to bring the client perspective into outcome measurement." They measure "the importance of different decrements in functioning on an individual's perception of his or her quality of life."
4. *Adverse events* refer to negative outcomes (e.g., hospitalization, mortality, incarceration) that result from system problems that could be avoided with appropriate care.
5. *Satisfaction with care* refers to the consumer's perception of the quality of the care that she or he received.

We have incorporated a lot of these in our AB 34 data. We took a different approach with AB 34 and you can tell by the outcomes language that we used. This is what we wrote when we decided to draw up the bill. Because when AB 34 was written they really said that this is what should happen as a result of this system:

1. Consumer should live in the most independent, least restrictive housing feasible in the local community.
2. Engage in the highest level of work or productive activity appropriate to their abilities and experience.
3. Create and maintain a support system consisting of friends, family, and participation in community activities.
4. Access an appropriate level of academic education or vocational training.
5. Obtain an adequate income.

6. Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions which affect their lives.
7. Access necessary physical health care and maintain the best possible physical health.
8. Reduce or eliminate antisocial or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system.
9. Reduce or eliminate the distress caused by the symptoms of mental illness.
10. Have freedom from dangerous addictive substances.

The other thing that you need to know about AB 34 is that the kinds of data that we measure is what we call "Real Time" data.

According to the Objective Quality of Life (OQOL) data:

- Consumer statuses on all relevant domains are assessed for the year prior to enrollment and on the day of enrollment.
- Whenever a status change occurs, it is entered into the information system.
- Comparisons can be made between pre-enrollment status and post-enrollment status.
- Programs have "up-to-the-day" knowledge of the current status of all of their consumers (e.g., what percentage are currently homeless, working, in school, hospitalized, etc.)

At this point Mr. Pilon showed several slides as examples of some of the data that can be pulled from this OQOL system.

We won't go into the entire AB 34 program but I am going to say just one thing about the culture of AB 34 program: we do "whatever it takes". It's the intensive case management, that people have small case loads of 15 to one. So, your case manager is really quite closely connected to you and there are things like flexible funding. Unlike most mental health programs AB 34 allowed mental health dollars to be used for things like hotel vouchers. Person is coming out of jail, there's no place to go, you can put them in a hotel right away rather than go through that revolving door – heading back to jail because you couldn't find them a vacancy.

Having these kinds of data also allows you to establish benchmarks for yourself and compare yourself to other programs. You can go on our website (www.ab34.org) and compare your county to any county or to the rest of the State to see the kinds of reductions you are getting in homelessness or incarceration or hospitalization. If your results for your county are better or worse, that tells you something about what you are doing wrong and what you are doing right.

I am going to tell you about the initial focus of the Performance Measurement Advisory Committee. We have only met once and the Dept. of Mental Health is very clear that given the success of the use of AB 2034 outcomes is that they want to adopt these kinds of outcome status changes as a key part of performance measurement across the State.

- Adoption of Key Event Tracking (AB 34 Objective Quality of Life Outcomes) as the initial basis for performance measurement.
- MHSA Services and Supports funding likely to be available on January 1, 2006. The State is determined to have outcomes tracking systems in place for this in time this money comes out.
- Streamlining Data Elements
- Task Force meeting to make modifications for Children, Transition Age Youth, and Older Adults.

Commissioner Diaz: From experience, these evaluations, these outcome measures, all are done by the person giving services. Where do you get the outcome measures of parents and family of children when they are the ones getting the services? Because they seem real and good for the person that is doing the evaluation, the clinician is doing the services, may not be what the family thinks. In other words, I would get an outcome measure where we are actually measuring the reality of the parents and family of the child, not just what the providers or clinicians think what works and what not. Is there a way?

Dr. Pilon:
Yes, there is. The consumer satisfaction measurement about whether they feel what's being offered to people is good. We do have consumer satisfaction measures. But these don't exhibit much variance. Everybody seems to be relatively satisfied with where they are. I need to point out that the AB 34 system is not evaluation of where people are, it's just a statement about if this person in jail. So, the clinician is the most logical person to say where is this person living.

Commissioner Diaz:
They give you personal satisfaction survey in their office in front of the clinician and you are afraid sometimes to respond that it is not working for fear that the little bit help that you are getting is going to go away. So, that's where I am pushing. What is it that we are doing to get the true measurement?

Dr. Pilon:
Generally speaking, people are unsatisfied with consumer satisfaction surveys. That is one reason why we went into this system instead.

Ms. Wynne:
I see that if you have a case load of 15, this could work. What if you have a case load of 100 or 150?

Dr. Pilon:
I am actually working on modification of this system that will allow you to keep this kind of data tracked even with a larger caseload.

Because of the success of AB 34 the State is really moving down that track. We are going to try to find out how we can modify according to the Transition Age Youth (TAY) issue,

the Children issue, the Older Adult issues. But there are some key things we need to look at.

- There is this implementation of the information management system. If the State Department of Mental Health is determined to try to create information management system and time is really short and so the concern has to be as well even if we manage to get this data element defined, how are we going to get this information into any coherent form into a database.
- We are also talking about training direct service staff in key event tracking.
- Third point is auditing and verifying this data. The State will have to implement some kind of verification system to make sure that the data that's coming in is in fact accurate.
- The next is risk adjustment. If you have a county that says that we have managed to go from 50% of our consumers who were homeless when they came into the program and now only 10% are homeless. Yet, another county that says we had 50% of our consumers homeless when they came into the program and now we have actually 30%. County A says that we are doing better than County B and County B says we have harder clients than you do. So, there has to be some way of evaluating the level of need of the people who are coming in.
- We also have to match the level of service to level of need. This is called the "Flow" problem. What we have found is that people get better when they get good service. What happens is that people stay in the program, they keep receiving these very intensive level of services even after they probably no longer need that.

Now, this is tied to the whole idea of recovery. People do recover. Recovery as the basis for services under MHSA says, "Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

1. To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination."

So, are we helping people to recover? That is the key idea of MHSA. But the problem is how you define recovery. Many consumers speak of recovery in terms of their own internal experience – often phrased in such terms as "becoming empowered," "taking charge of their own lives," "improving their self-esteem," or "becoming responsible for themselves." Others speak of mitigation of psychiatric symptoms (or symptom distress) and improvement in functioning. To me that seems to be the key element: identifying and taking on meaningful roles in one's life.

There are other difficulties in measuring recovery. How does the recovery concept apply to children and youth? Can and should it be modified to reflect "DIScovery?" Does recovery mean something different for transition age youth and older adults? Do we need to take into account "culture-specific" meanings of recovery? Should we measure

consumer's internal subjective experience of recovery (e.g., hope) or should we measure objective and observable changes in the quality of their lives?

Generic Treatment (evidence based practice) Logic Model: Different counties use different evidence based practices. They tend to think that usually these are the kinds of things we create when we use medications, we help people increase their skills, their functioning, those kinds of behaviors. People experience recovery, they are more empowered, they have more meaningful roles, etc. They also experience decreased symptoms and symptom distress and maybe decreased substance abuse. And when they experience those things it results in long term outcomes like reduced hospitalization, reduced incarceration, increased residential independence and stability, increased employment. This is the log we carry around in our heads.

This is the model I would like you to consider instead. I would like to talk about "Recovery Culture" in which we embed the evidence based practice. There are a lots of differences we see between programs which can be explained by the culture of the program and when they created that program rather than specific treatments or rehabilitation practices that they use. Welcoming is the key aspect of that charity, treatment, rehabilitation, advocacy and graduation, all of those things make up the program culture. And yet the key point is that it's not a one way street. Most times we think that it's the internal changes then produce the external quality of life changes, like increased residential stability, reduced hospitalization, reduced incarceration, increased employment.

Components and Stages of Recovery:

Components of Recovery	Stages of Recovery
Level of risk	Extreme Risk
Level of engagement	High risk/unengaged
Level of skills and supports	High risk/engaged
	Poorly coping/unengaged
	Poorly coping/engaged
	Coping/rehabilitating
	Early recovery
	Advanced recovery

In our own programs, we are trying to say that we need to be able to move some of these people. They come into our program, they are high risk and not engaged with the system, so, how long does it take us to get them from that sort of stage to coping/rehabilitating, early recovery to where they no longer need the public mental health system at all when they are in advance recovery. That's our suggestion in terms of coping with this problem, how we help people move through the system.

Are different services more or less effective in different stages of recovery? Can we use the stages to assign consumers to different types of care? What is the typical path of a person in recovery? If a person enters our system as "high risk, unengaged," how long

(on an average) will it take for her to become "coping/rehabilitating?" How long until she is in "advanced recovery." Is it possible to establish "benchmarks" for service providers? Can we hold service providers accountable for moving people through the stages? Should we set expectations for service providers to move certain percentages of their consumers to higher stages over a set amount of time?

I think that anything we do under the MHSA should pass what I call the "average citizen" test. Would the average citizen understand the data produced by this particular outcome measure? Would the average citizen approve of his/her money being spent to support a mental health system or program that measured its effectiveness through the data produced by this particular outcome measure? If we can't explain it to the average person, then we are going to have problems justifying it. I think that has been a problem with lot of the outcome measures. People look at them and say that they don't really get it.

Commissioner Feldman:

1. In the last seven or eight years, there has been lot of impressive work done in outcomes and the Commission will have access to that expertise.
2. There is some question about who in fact should be responsible for doing the outcome studies. I know that within the department perhaps they feel like it should be their responsibility. But seems to me that given the scope and magnitude of this program and the importance of it, the notion of having outside entities conduct this evaluation, strikes me as being something this Commission ought to consider. In terms of credibility it just always seems to be better to not have the people who are operating and responsible for the program doing the evaluation. If in fact, the evaluation is done by an outside credible organization, I think it would add credibility to this entire effort.

The other thing that I would like to put on the table is to what extent, in fact there should be common objectives against which we measure our performance throughout the entire state for every county, and to what extent, there may be substantial significant difference between the counties. What are the opportunities to have the criteria and have their success measured somewhat differently from other counties. Recovery is recovery. But, as Commissioner Henry so rightfully pointed out – not much of what we have talked about here so far goes to the heart of some of what the Commission is responsible for. If, in fact, it is the case, if transformation is an important objective, what kind of criteria do you use for this?

Commissioner Doyle:
I have some general concerns about designing a program where process for adults is the same for children. That process does not work very well. Children are not small adults. I have concerns about evaluation outcome systems for adults and integrating kids into this, I am not sure it's going to work.

I also have some concerns that we have to keep it simple. We have to have outcome measures that are easy to get, easily understandable, and don't require unreasonable amounts of staff time.

When we are talking about children and adolescents, we need to listen to their families, their parents, what's going on, what's working and what's not.

Dr. Pilon:
We have to be really careful about asking our staff to collect yet more data. But that's why I think it's absolutely critical that we come to some consensus on the priority of the data and from what we are going to get the most bang for the buck. What is going to the greatest extent possible, demonstrate to the public that their dollars are being spent well.

Commissioner Diaz:
I would like to see something on paper that will work for children and transitional age youth.

Dr. Pilon:
The committee is establishing task forces to try to see where the correspondences are between the kinds of data we are collecting for adults and the kinds of data we are collecting for TAYs and children. Maybe there aren't any correspondences. Maybe you can't collect the same kind of data. There are a lot of children's people on that committee and they are going to be giving it their look. There is some feeling out there that the reason why the Children's System of Care got defunded because it didn't have the kinds of outcomes that were comparable to AB 34 system. We should be looking for different outcomes for children than we do for adults.

Commissioner Prettyman:
There are definite different needs for older adults as well.

Commissioner Prettyman wanted to know who the task force was, who are the people on this task force and can they get a list of these people.

Chair:
If you could help us identify exactly what is going on within the Department now when it comes to developing outcome measures and then how you see, from your vast experience with this, how we, in our Outcomes Committee, ought to interrelate with the work that is already being done so that we, in the end, get a product which we are all proud of.

Dr. Pilon:
The State has taken the approach that they want to come up with a system for MHSA that produces the same general types of outcomes that were successful in AB 2034. They are calling this Key Event Tracking. Our number one priority, everything else takes a backseat to this, is that we will come up with a key event tracking system for adults, TAYs, children and older adults. And task forces have been established out of that committee to create that. And we will have this in place by January 1, 2006.

Chair:
How do we assist you and add value to what's already being done?

Dr. Pilon:
I think the difficult discussions will happen after the key event tracking is in place. There is the Information System that needs to be established for that but, then the discussions will happen about what outcome measures get put in place.

Chair asked Dr. Pilon to explain target progress. Dr. Pilon said that progress that he is looking at is that, are programs helping people to find meaningful roles in their lives, to support themselves, to become more coping individuals, are we keeping them out of the hospitals. General categories of those things – are we moving people through those stages. As you move through stages of recovery, people are going to feel more hopeful. But lot of people are not going to buy that. They are going to say that no, we have to have specific measures of hopefulness and that's where the difficult arguments are going to happen starting around January 1st once we get past this key even tracking.

IX. OAC Guidelines for How the Commission Reviews County Community Services and Supports Plan

Overview: The primary purpose of this cycle of county plan reviews by MHSOAC is to inform the Commission on how best to fulfill its oversight and accountability responsibilities into the future. Through this review, the Commission hopes to develop a picture as to how MHSA statewide expenditures will transform the way public mental health services are perceived and delivered. This picture will guide MHSOAC as it defines what the Commission will be looking for from counties in subsequent plans. The MHSOAC review is to add value to and compliment the DMH review.

Review Guidelines: The following six guidelines grew from the Commission's discussions at its August 2005 Retreat:

1. **Client and Family Involvement:** Is there significant participation and involvement of clients and family in all aspects of the county's mental health system, including but not limited to: planning, policy development, service delivery and evaluation?
2. **Cultural Competency:** Does the plan identify the underserved populations in the county and have strategies for outreach to those populations? Does the plan pay attention to the service and system disparities among population groups? Are the service planning and delivery system culturally and linguistically responsive to clients and families' race, ethnicity, gender, sexual orientation and religious/spiritual beliefs?
3. **Countywide Collaboration:** Does the plan include strategies to closely work with other local agencies and resources in the community to provide integrated and comprehensive mental health services? This would include but

not be limited to such systems as child welfare, juvenile justice, law enforcement and criminal justice, education and primary health care.

4. **Priorities:** What are the county's services and support priorities? How do these priorities compare and contrasts with the Commission's priorities as discussed at the Commission's August 2005 retreat?
5. **Regional Needs:** When looking at the composite picture of the plans from any one region, how do these plans fit together as an integrated whole to serve the mental health needs of the region's population? From a regional perspective, where are the services and support gaps?

Areas of focus for the Commission's work:
At its August 22, 2005 retreat, the Commission discussed these key areas for its work.

- Continuum of true care
- Cultural competency
- Consumer and family driven
- Homelessness
- Recovery
- Supportive housing and reduction in institutional care
- Decriminalization of mental illness
- Transformation of the Mental Health Workforce
- Employment of clients and family, including employment in mental health field
- Children, especially keeping children out of the system and education of children and parents as part of stigma reduction.
- Support network of systems to provide a path to independence
- Stigma reduction
- Coordination at all levels of California government; supporting other states and the nation to adopt similar programs as the MHSA

Chair:
We are going to spend 60% to 80% of the money in years one, two and three on backend services. We will spend 20% on prevention but the plans ought to reflect a movement towards those numbers. So, in year one, it's not that we are going to expect every dime to be spent on prevention early intervention, but we want to see the thinking about how the counties are going to integrate the prevention piece with the ongoing services.

Commissioner Doyle:
We need to ask questions like how many kids does this county have? How are the changes that we are proposing going to offset that. How many homeless people does this county have? How are the proposals that they are making going to reduce the number of people who are homeless? I would like to see something like where are you now and how is your proposal going to reach for transformation.

Commissioner Prettyman:
I would really like to see when the plans come in that it doesn't just say that we met with a group of stakeholders and consumers and family members and they said this. I would

like to hear what the consumers and family members said, quotes, how they met with these people and what was suggested by the consumers and family members.

Commissioner Gayle:
I was thinking about the commissioners and how involved are we in our own separate counties and understanding what it takes for these counties to pull these plans together. I know I have worked extensively with these focus groups, going to meetings at night, doing a multitude of different things but, I don't know how many of the commissioners on this Commission are doing any work with the counties. I know what it is taking for these counties to produce a plan and continue working with the clients just like this money had never even came into the system cause the clients needs did not stop so that we can develop a plan. So, I would like to caution people really getting zealous until you have walked a mile in these county's shoes and see what it takes to outreach to some of these hard to serve people who will not come to meetings cause they have never been invited to the table before, they get input and then say well, this is not a good plan! Well, if you go to some of these meetings, Commissioners, and find out what's going on in your county, we can cover a multitude of counties to see how the plans are going or what it really looks like and then we will be informed on these plans when they come in. It is interesting that if you are judging something and you haven't seen how the process works, it's easy to sit on a high chair and point when you don't know what it took for them to do what they are doing. I see at some of these rural counties, they don't have the staff to pull together all of this stuff. Some of these counties don't have the staff to support the people that they are working with. I really want us to get out as commissioners in our counties when they are doing these outreach and be a part of them.

Chair:
Are the six guidelines which have been articulated here with the addition of the philosophy of prevention, with the overarching umbrella of transformation, on the right track that we can hand this over to Tricia and Jerry and any other interested member of the commission and put together our mode of review.

Commissioner Prettyman wanted to make sure that we add recovery to the list of guidelines.

MOTION: To essentially empower the two new chairs of the committee working together with your vice-chair and the staff and to take this guideline on the guidelines and to develop the review process for the commission.
Motion was passed unanimously.

Members of the public were given second opportunity to speak if they wanted to comment on anything for the next time.

Chair stated that he will follow through on our commitment to have Advisory Committee made up of consumers and family members and any other advisory committees which allow sustained information from the stakeholders.

In response to Carol Hood's question, Chair responded that the very first thing that our chairs need to do here is sit down with her and work out those time lines to review the plans, so that there is no undue delay between the Department's tentative approval of plan, the Commission's committees announcing the recommendation and what the role of the full commission will be county by county. We need to be thorough but not burdensome.

X. Adjournment

Chair Steinberg thanked the members of the public and fellow Commissioners for their participation.

The meeting was adjourned at 4:00 p.m.

Approved: October 26, 2005